New Hampshire

XOLAIR® (Omalizumab)

First Health Services Corporation
A Coventry Health Care Company

NH Medicaid Prior Authorization Request Form

Fax: 1-888-603-7696 Phone: 1-866-675-7755

Date of Medication Request: ___ ___ /___ ___ /___ ___ ___ ___

Section I: Patient Information and Medication Requested:

Name: (Last, First) _____ NH Medicaid Number:___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ Gender: ☐ Male ☐ Female

Drug Name:_____ Strength:_____

Dosing Directions:_____ Length of Therapy:_____

Section II: Clinical History:

1. Is the patient 13 years of age or older? ☐ Yes ☐ No
2. Does the patient have a diagnosis of moderate to severe persistant asthma? ☐ Yes ☐ No
3. Is the patient symptomatic despite taking medium to high dose inhaled corticosteroids or oral steroids in combination with either a long-acting $beta_2$ agonist, a leukotriene modifier, or theophylline? ☐ Yes ☐ No
4. Has the patient's allergy been confirmed by skin testing or invitro activity to the allergen? ☐ Yes ☐ No
5. Is the patient's IgE result > 30IU/mL and ≤ 700 IU/ml? _____IU/ml ☐ Yes ☐ No
6. Is the patient poorly compliant on current asthma treatment plan? ☐ Yes ☐ No
7. Is a pulmonologist, allergist, or immunologist prescribing this medication, or has one of these specialists been consulted in this case? ☐ Yes ☐ No
8. Is the patient an active smoker? ☐ Yes ☐ No
9. Is this patient being treated exclusively for peanut allergy? ☐ Yes ☐ No
10. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page_____

Section III: Prescriber Information:

Name: _____ DEA Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Fax Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____
Signature of Prescribing Provider